DEPARTMENT OF HEALTH & HUMAN SERVICES

National Medicare

TRAINING PROGRAM

CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Medicare Rights and Protections Module 2



# ...helping people with Medicare make informed health care decisions



# Centers for Medicare & Medicaid Services National Train-the-Trainer Workshops Instructor Information Sheet

#### **Module 2: Your Medicare Rights and Protections**

#### **Module Description**

Module 2-Your Medicare Rights and Protections explains the rights and protections afforded to people enrolled in Original Medicare, Medicare health plans (such as a Medicare Advantage Plans), Medicare Prescription Drug Plans, and other Medicare health plans (such as a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly). This module also describes appeals processes and timeframes.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics
2	Session Objectives
4-12	Overview of Your Rights & Protections
13-27	Your Rights in Original Medicare
28-34	Your Rights in MA Plans & Other Plans
35-52	Rights in Medicare Prescription Drug Plans
53-56	Your Rights in Other Settings
57-64	Medicare Privacy Practices
65-70	Information Sources

#### **Objectives**

- Explain Medicare rights and protections
- Understand Medicare privacy practices
- Find more information and resources

#### **Target Audience**

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

#### **Learning Activities**

This module contains 4 interactive learning questions, scenarios and case studies designed to prompt discussion and give participants the opportunity to apply the module concepts in a real-world setting.

#### **Handouts**

Slides 18, 32, and 46 are provided as full page handouts in the Appendix of this workbook. You may want to refer to these during your training if you provide copies of the workbooks to attendees. You may also wish to make copies of the handouts and distribute them as learning aids.

#### **Time Considerations**

The module consists of 70 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

#### References

 Your Medicare Rights and Protections, CMS Product No. 10112 available at medicare.gov/ Publications/Pubs/pdf/10112.pdf.

# Medicare Rights and Protections Module 2

Module 2 *Medicare Rights and Protections* explains the rights and protections afforded to you whether you are enrolled in Original Medicare, a Medicare Advantage Plan (like an HMO or PPO), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or Medicare Prescription Drug Plan.



This symbol is used in this presentation to highlight changes based on the Affordable Care Act.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid. The information in this module was correct as of April 2011. To check for an updated version of this training module, visit cms.gov/NationalMedicareTrainingProgram/TL/list.asp on the Web. To check for updates regarding Affordable Care Act, visit www.healthcare.gov.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

# **Session Objectives**

- This session will ensure you can
  - Explain Medicare rights and protections
  - Understand Medicare privacy practices
  - Find more information and resources

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Your Medicare Rights and Protections

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This session will ensure you can

- Recognize Medicare rights and protections
- Explain Medicare privacy practices
- Find more information and resources

#### Lessons

- 1. Overview
- 2. Rights in Original Medicare
- 3. Rights in Medicare Advantage and Other Medicare Plans
- 4. Rights in Medicare Prescription Drug Plans
- 5. Rights in Other Settings
- 6. Medicare Privacy Practices
- 7. Information Sources

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Your Medicare Rights and Protections

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#### This module includes lessons on

- 1. Overview of Your Medicare Rights and Protections
- 2. Rights in Original Medicare
- 3. Rights in Medicare Advantage Plans and Other Medicare Plans
- 4. Rights in Medicare Prescription Drug Plans
- 5. Rights in Other Settings
- 6. Medicare Privacy Practices
- 7. Information Sources for Medicare Rights and Protections



This is an overview of your Medicare rights and protections.

# **Guaranteed Rights**

- Protect you when you get health care
- Make sure you get medically necessary services
- Protect you against unethical practices
- Protect your privacy

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Your Medicare Rights and Protections

- No matter how you get your Medicare, you have certain rights and protections designed to
  - Protect you when you get health care
  - Make sure you get the health care services that the law says you can get
  - Protect you against unethical practices
  - Protect your privacy

- Be treated with dignity and respect
- Be protected from discrimination
  - Race, color, national origin
  - Disability
  - Age
  - Religion
  - Sex (under certain conditions)
- Call the Office for Civil Rights -1-800-368 1019
  - TTY users call 1 800 537 7697

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Your Medicare Rights and Protections

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- All people with Medicare have the right to
  - Be treated with dignity and respect at all times
  - Be protected from discrimination
    - Discrimination is against the law. Every company or agency that works
      with Medicare must obey the law, and can't treat you differently because
      of your race, color, national origin, disability, age, religion, or sex (generally
      limited to complaints of discrimination filed against providers of health
      and social services who receive Federal financial assistance).



If you think you haven't been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or visit hhs.gov/ocr. TTY users should call 1-800-537-7697.



- Have personal and health information kept private
- Get information in a way you understand
  - Medicare
  - Health care providers
  - Contractors (under certain circumstances)

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Your Medicare Rights and Protections

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- All people with Medicare have the right to
  - Have your personal and health information kept private.
    - To learn more about this right



If you have Original Medicare, see the "Notice of Privacy Practices for Original Medicare" in your "Medicare & You" handbook. Visit www.medicare.gov/Publications to view the handbook or call 1-800-MEDICARE to ask for a copy.

- o If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.
- Get information in a way you understand from Medicare, health care providers, and under certain circumstances, contractors.

- Get information to help you make decisions
  - What is covered
  - What Medicare pays
  - How much you have to pay
  - What to do to file a complaint or an appeal
- Have questions about Medicare answered

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Your Medicare Rights and Protections

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- All people with Medicare have the right to
  - Get understandable information about Medicare to help you make health care decisions, including what is covered, what Medicare pays, how much you have to pay, and what to do if you want to file a complaint or an appeal
- Have your questions about Medicare answered



Visit www.medicare.gov.



Call 1-800-MEDICARE. TTY users should call 1-877-486-2048.

- Call your State Health Insurance Assistance Program (SHIP). To get the most up-to-date SHIP phone numbers, call 1-800-MEDICARE, or visit www.medicare.gov/contacts.
- Call your plan if you're in a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan

- Have access to doctors, specialists, hospitals
- Learn about your treatment choices
  - Clear language
  - Participate in treatment decisions

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Your Medicare Rights and Protections

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#### All people with Medicare have the right to

- Have access to doctors, specialists, and hospitals.
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions.
  - You have the right to participate fully in all your health care decisions. If you
    can't fully participate, ask a family member, friend, or anyone you trust to help
    you make a decision about what treatment is right for you.

- Health care services
  - In a language you understand
  - In a culturally-sensitive way
- Emergency care when and where you need it
  - If your health is in danger, call 911

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Your Medicare Rights and Protections

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All people with Medicare have the right to

 Get health care services in a language you understand and in a culturallysensitive way



For more information about getting health care services in languages other than English, call the Office for Civil Rights at 1-800-368-1019, or visit www.hhs.gov/ocr. TTY users should call 1-800-537-7697.

- Get emergency care when and where you need it
  - If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.
  - To learn about emergency care



In Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

• In a Medicare Advantage Plan or other Medicare health plan, your plan materials describe how to get emergency care.

- Have a claim for payment filed with Medicare
- Get decisions about
  - Health care payment
  - Services
  - Prescription drug coverage
- Get a review (appeal) of certain decisions
  - Health care payment
  - Coverage of services
  - Prescription drug coverage

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Your Medicare Rights and Protections

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#### All people with Medicare have the right to

- Have a claim for payment filed with Medicare and get a decision about health care payment, services, or prescription drug coverage.
  - Even when your doctor says that Medicare won't pay for a certain item or service, you have a right to request the doctor file the claim with Medicare.
     When a claim is filed, you get a notice from Medicare letting you know what it will and won't cover. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.
- Get a review (appeal) of certain decisions about health care payment, coverage of services, and prescription drug coverage.
  - If you disagree with a decision about your claims or services, you have the right to appeal. For more information:



Visit www.medicare.gov/appeals.



Call the SHIP in your state. To get the most up-to-date SHIP phone numbers, call 1-800-MEDICARE, or visit www.medicare.gov/contacts. TTY users should call 1-877-486-2048.

• If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

- File complaints
  - Sometimes called grievances
  - Including complaints about the quality of care
    - · In Original Medicare, call the QIO
    - In Medicare Advantage or other Medicare plan, call the QIO, your plan, or both

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Your Medicare Rights and Protections

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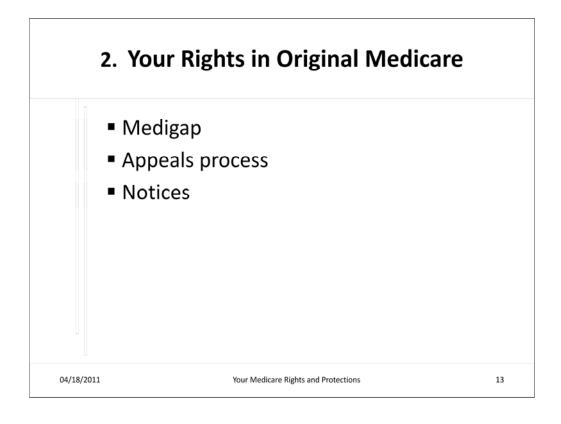
- In addition to the rights just mentioned, all people with Medicare have the right to
  - File complaints or grievances about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
  - If you're concerned about the quality of care you're getting



In Original Medicare, call the Quality Improvement Organization (QIO) in your state to file a complaint. Call 1-800-MEDICARE or visit www.medicare.gov/contacts to get your QIO's phone number.



In a Medicare Advantage or other Medicare health plan, call the QIO, your plan, or both. If you have End-Stage Renal Disease and have a complaint about your care, call the ESRD Network in your state. To get this phone number, call 1-800-MEDICARE, or visit www.medicare.gov/contacts.



- In additional to the rights described in the previous section, you have additional rights when you are enrolled in Original Medicare.
  - Medigap
  - Appeals process
  - Notices

# **Your Rights in Original Medicare**

- See any participating doctor or specialist
- Go to any Medicare-certified hospital
- Get information when Medicare doesn't pay
  - Notices
  - Appeal rights

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Your Medicare Rights and Protections

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Your rights when you are enrolled in Original Medicare include the following

- See any participating doctor or specialist (including women's health specialists), or go to any Medicare-certified hospital;
- Get certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care.

#### **Medigap Rights in Original Medicare**

- Buy a Medigap policy
  - Also called Medicare Supplemental Insurance
  - Guaranteed issue rights
    - Can't deny you Medigap coverage
    - · Can't place conditions on coverage
    - Must cover pre-existing conditions
    - Can't charge more because of past or present health problems
  - Some states give additional rights

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Your Medicare Rights and Protections

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- Your rights when you are enrolled in Original Medicare include the following
  - Buy a Medigap (Medicare Supplemental Insurance) policy.
    - In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare coverage, such as coinsurance amounts.
    - Medigap policies must follow Federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
    - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a "standardized" Medigap policy. These policies are identified by the letters A,B,C,D,F,G,K,L,M, and N.
      - The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
    - You have the right to buy a Medigap policy during your Medigap open enrollment period. While the insurance company can t make you wait for your coverage to start, it may be able to make you wait for coverage of a pre-existing condition.
- When you have guaranteed issue rights the company:
  - Can't deny you Medigap coverage or place conditions on your policy
  - Must cover you for pre-existing conditions
  - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies

**Note:** Module 3, *Medigap*, describes these situations.

# **Appeal Rights in Original Medicare**

- File an appeal
  - A service or item isn't covered
  - Payment for a service or item is denied
  - Question amount Medicare paid

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Your Medicare Rights and Protections

- In Original Medicare, you have the right to a fair, timely, and efficient appeals process.
- You can file an appeal if:
  - A service or item you got isn't covered and you think it should be
  - Payment for a service or item is denied and you think Medicare should pay for it
  - You question the amount that Medicare paid for a service

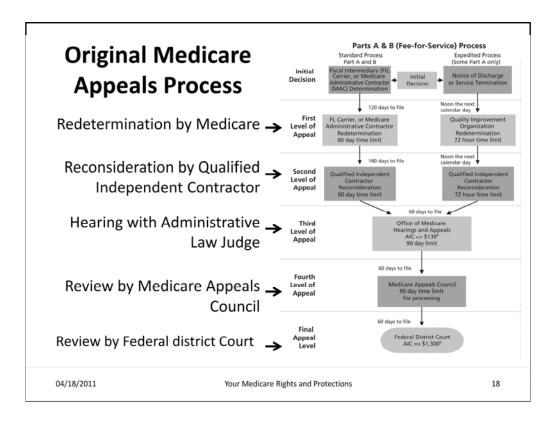
# **How to Appeal in Original Medicare**

- "Medicare Summary Notice" (MSN) will tell you
  - Why Medicare didn't pay
  - How to appeal
  - Where to file your appeal
  - How long you have to appeal
- Collect information that may help your case
- Keep a copy of everything you send to Medicare

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Your Medicare Rights and Protections

- In Original Medicare, when you get a Medicare-covered item or service, you will get a "Medicare Summary Notice" (MSN). This notice will tell you why Medicare didn't pay, how to appeal, where to file your appeal, and how long you have to appeal.
- If you decide to appeal, ask your doctor, health care provider, or DME (durable medical equipment) supplier for any information that may help your case.
- Keep a copy of everything you send to Medicare as part of your appeal.



There are five levels in the appeals process in Original Medicare. Look at the job aid section of your CD suite or wafer for a chart of the Part A, B, C, and D Appeal Processes.

- **1.** Redetermination by the company that handles claims for Medicare within **120** days from the date you get the MSN. Details are on the MSN.
- 2. Reconsideration by a Qualified Independent Contractor (QIC) (a contractor that didn't take part in the first decision). Details are included in the redetermination notice.
  - Contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal.
- 3. Hearing before an Administrative Law Judge (ALJ) (the amount of your claim must meet a minimum dollar amount, which is updated yearly: \$130 in 2011). Send the request to the ALJ office listed in the reconsideration notice.
- **4. Review by the Medicare Appeals Council (MAC).** Details on how to file are included in the ALJ's hearing decision. There is no minimum dollar amount in order to get your appeal reviewed by the Medicare Appeals Council.
- 5. Review by a Federal district court. To get a review by a Federal court, the remaining amount in controversy of your case must meet a minimum dollar amount, which is updated yearly: \$1,300 in 2011.

**Note:** This chart is available in the corresponding workbook (see Appendix A).

#### **Fast Appeal**

- Sometimes called an expedited determination
- Receiving care and being discharged too soon
  - Appeal to Quality Improvement Organization (QIO)
  - Notice at least 2 days before services end
  - QIO will decide if services should continue
- Right to a fast appeal is the same
  - Original Medicare
  - Medicare Advantage Plan or other health plan

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Your Medicare Rights and Protections

- If you are admitted to a hospital or skilled nursing facility, or you are receiving care from a noninstitutional provider, such as home health, hospice, or a comprehensive outpatient rehabilitation facility (CORF)
- You have the right to receive a fast appeal (sometimes called an expedited determination) by an independent reviewer called a Quality Improvement Organization (QIO) if you think you are being discharged too soon.
  - Your provider will give you a notice at least 2 days before your services end that will tell you how to ask for a fast appeal
    - If you don't get this notice, ask your provider or plan for it
  - The QIO will decide if your services should continue
- Your provider cannot bill you while the QIO is making its decision.
  - If you are a hospital inpatient, you will not be responsible for charges incurred while waiting for the QIO's decision even if the QIO decides the discharge was appropriate.
  - If you are not a hospital inpatient, you may be responsible for charges incurred while waiting for the QIO's decision if the QIO decides that the discharge was appropriate.
- Your right to a fast appeal is the same whether you are in Original Medicare, Medicare Advantage Plan (like an HMO or PPO), or other Medicare health plan.

## **Fast Appeals**

- Ask your doctor for information
- Call the QIO to request a fast appeal
  - No later than noon the day before coverage ends
- If you miss the deadline, you still have appeal rights

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Your Medicare Rights and Protections

- You may ask your doctor for any information that may help your case if you decide to file a fast appeal.
- You must call your local QIO to request a fast appeal no later than noon on the day before your notice says your coverage will end.
  - The number for the QIO in your state should be on your notice. You can also call 1-800-MEDICARE (TTY users should call 1-877-486-2048)
- If you miss the deadline, you still have appeal rights:
  - If you have Original Medicare, call your local QIO
  - If you are in a Medicare Advantage plan, call your plan. Look in your plan materials to get the telephone number.
- Contact your local SHIP if you need help filing an appeal.

#### Scenario

■ Dora was recently hospitalized for congestive heart failure. She is enrolled in Original Medicare and is highly dissatisfied with the care she received while she was in the hospital. Dora believes Medicare beneficiaries should be treated with dignity and respect. How can Dora make sure Medicare officials are made aware of her experience?

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- What are Dora's options?
- Answer: Dora can file a quality of care complaint with the QIO.
  - What other options might Dora have?
    - She could also file a complaint with the Joint Commission by calling (630) 792-5000 or she may submit her complaint online by visiting their website at
    - jointcommission.org
    - Another option would be to contact the DHHS/Office of Civil Rights by calling 1-866-627-7748 or 1-800-537-7697 for TTY users
    - She may also visit the OCR website at <a href="https://html.nc.nc/html">hhs.gov/ocr/office/index.html</a>

## **Protection from Unexpected Bills**

#### **Advance Beneficiary Notice of Non-Coverage (ABN)**

- Given by health care provider or supplier
- Says Medicare probably (or certainly) won't pay for an item or services
- Used only in Original Medicare
- Not required for items or services excluded under law
- Will ask you to choose whether to get services
- Will ask you to confirm you read/understood notice

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Your Medicare Rights and Protections

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- You are protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations he or she will give you a notice that says Medicare probably (or certainly) won't pay for an item or service. This is called an Advance Beneficiary Notice of Noncoverage (ABN). The ABN is used only in Original Medicare for Part B services and Part A services provided by hospices and religious nonmedical health institutes.
- Doctors and suppliers are not required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), such as routine physical exams (except the annual wellness exam), routine eye exams, dental services, hearing aids, and routine foot care; however, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.
- You may still get the service, you will be asked to choose an option and sign to say that you have read and understand the notice.
- If you choose to get the items or services listed on the ABN, you will have to pay if Medicare doesn't.
  - In some cases, the provider may ask for payment at the time the service is received.
- Providers (including independent laboratories), physicians, practitioners, and suppliers will use the ABN (Form CMS-R-131) for situations where Medicare payment is expected to be denied because the item or service may not be reasonable and necessary.

**Note:** A copy of the ABN is provided in the corresponding workbook (see Appendix B). It is also available on the web at www.cms.gov/BNI/02\_ABN.asp

### Types of ABNs

- Advance Beneficiary Notice of Noncoverage (ABN)
- Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
- Home Health Advance Beneficiary Notice (HHABN)
- Hospital Issued Notice of Non-coverage (HINN)

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- There are four types of ABNs for people with Original Medicare. These notices explain that you may be liable for the cost of certain services under certain conditions. The notices include
  - Advance Beneficiary Notice of Noncoverage (ABN) only used for Part B services and for Part A when hospice services or services in a religious non-medical healthcare institute are provided
- There are other types of liability notices for people with Original Medicare that are used in specific healthcare settings. Like the ABN, these notices explain that you may be liable for the cost of certain services under certain conditions. These notices include
  - Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) only used for skilled nursing facility care
  - Home Health Advance Beneficiary Notice (HHABN) only used by home health agencies
  - Hospital Issued Notice of Non-coverage (HINN) used for inpatient hospital care when the hospital thinks Medicare may not pay for some or all of your care



You can view or print beneficiary notices at www.cms.gov/BNI/.

Mr. Brady goes to the lab to have his annual screening PSA test. Because there is a frequency limitation on Medicare payments for PSA testing (once yearly), the lab issues an ABN. He is convinced that it has been more than a year since his last test so he checks Option 1 on the ABN and signs the form, and has his blood drawn for PSA testing. A week later he receives a bill from the lab for the PSA testing. The amount being billed is much more than he is usually charged.

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• Option 1 -- the beneficiary wants the service, wants the physician to bill Medicare and agrees to pay for the item/service up front.

#### Is Mr. Brady obligated to pay the bill?

- (a) No, he should not make any payments until he receives his MSN. The ABN will protect him from liability until a claim is denied.
- (b) Yes, the lab can request payment before a Medicare decision on payment is made. By signing the ABN, he has accepted financial liability for the item or service furnished.

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- Ask the participants for their thoughts on what the correct answer is and why.
- The PSA test falls under frequency limitation for screening tests so an ABN is appropriate. The beneficiary chose option 1 which obligates him to pay the lab whether Medicare covers the test or not, and obligates him to pay in advance of Medicare's coverage decision as the lab is allowed to charge him for the test up front. Since choosing Option 1 requires the lab to submit a claim to Medicare on Mr. Brady's behalf, the lab should refund any payments made by him if Medicare covers the test.

Mr. Brady receives his MSN from Medicare, and Medicare has denied payment because he exceeded the frequency limitation for this test. He notices that his lab bill exceeds the allowable Medicare amount by \$30. What amount should he pay to the lab?

- (a) Only the allowable Medicare amount.
- (b) The entire amount that the lab billed him for the PSA. (The usual and customary fee for non-Medicare patients.)
- (c) \$30

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- Again, ask for answers and explanations of why they chose that answer.
- Since the service is not covered by Medicare, charges are not limited to Medicare allowable amounts (i.e. limiting charge), the lab may charge the beneficiary the usual and customary amount for non-Medicare patients.

Mr. Brady reviews his records and finds that 362 days elapsed in between his PSA tests. He is upset, and does not feel that he should pay for the test. He calls you asking for his options. Does he have any options?

- (a) He must pay the lab bill, but he can file an appeal to see if Medicare will pay for the test.
- (b) He can ask the lab to resubmit the bill with a different date on it.
- (c) He can tell the lab that he is filing an appeal with Medicare and hold off on paying them until a decision on payment is made.

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Your Medicare Rights and Protections



In additional to the rights described in the first section, you have additional rights when you are enrolled in a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan.

# **Rights in Other Health Plans**

- Choose health care providers
- Get a treatment plan from your doctor
  - For complex or serious conditions
  - Directly see specialists as often as necessary

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If you're in a Medicare health plan, in addition to the rights and protections previously listed in the first section, you have the right to

- Choose health care providers within the plan, so you can get health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medial condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

### **Rights in Other Medicare Health Plans**

- Know how your doctors are paid
- A fair, efficient, and timely appeals process
  - -5 levels of appeal
  - Decision letter sent explaining further rights
  - Automatic review by IRE

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Your Medicare Rights and Protections

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If you're in a Medicare health plan, in addition to the rights and protections previously in the first section, you have the right to

- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
  - The appeals process consists of 5 levels
  - If coverage is denied at any appeal level, the enrollee will receive a letter explaining the decision and instructions on how to proceed to the next appeal level
  - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C Independent Review Entity (IRE)



See Rights & Protections Booklet for more details.

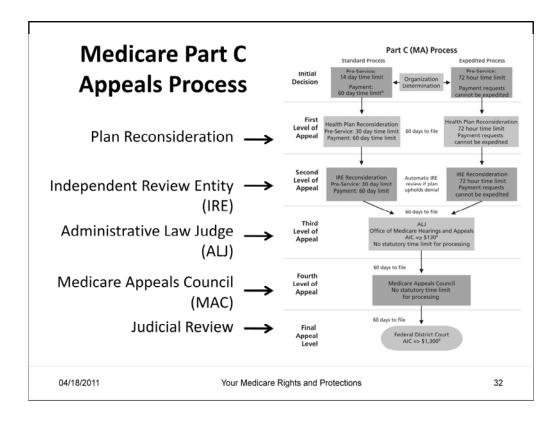
# **Rights in Other Medicare Health Plans**

- File a grievance about other concerns or problems
- Get a coverage decision or coverage information

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Your Medicare Rights and Protections

- If you're in a Medicare health plan, in addition to the rights and protections previously listed in the first section, you have the right to:
  - File a grievance about other concerns or problems with your plan. Check your plan's membership materials, or call your plan to find out how to file a grievance.
  - Get a coverage decision or coverage information from your plan before getting services.
  - Before you get a service or supply, you can call your plan to find out if it will be covered or get information about your coverage rules.
  - You can also call your plan if you have questions and home health care rights and protections. Your plan must tell you if you ask.



- This chart shows the appeal process for Medicare Advantage Plan or other Medicare health plan enrollees. The time frames differ depending on whether you are requesting a standard appeal, or if you qualify for an expedited (fast) appeal.
- If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You will get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.
- There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.
- After each level, you will get instructions on how to proceed to the next level of appeal. The five levels are of appeal are
  - Reconsideration by the plan
  - Reconsideration by the Independent Review Entity (IRE)
  - Hearing with the Administrative Law Judge (ALJ)
  - Review by the Medicare Appeals Council (MAC)
  - Review by a Federal district court

**Note:** This chart is available as a handout in the corresponding workbook (see Appendix C).

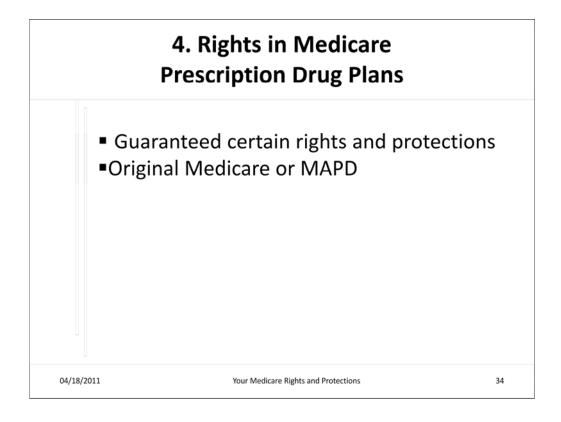
# **Rights When Filing Appeal with Plan**

- Right to your case file
  - Call or write your plan
  - May charge you a reasonable fee for copying and mailing

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Your Medicare Rights and Protections

- If you are in a Medicare Advantage or other Medicare health plan and you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your *Evidence of Coverage*, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.
- The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.



- Medicare works with private drug plans to provide beneficiaries with the high-quality, cost-effective drug coverage they need. All Medicare drug plans must make sure that the people in their plan, their enrollees, have access to medically necessary drugs to treat their conditions.
- If you are enrolled in a Medicare Prescription Drug Plan, you are guaranteed certain rights and protections. These rights and protections are the same whether you are in Original Medicare with stand-alone prescription drug plan or a Medicare Advantage Plan with prescription drug coverage.

# **Access to Covered Drugs**

- Must ensure enrollees can get drugs they need
- Must include more than one drug in each classification
- Must pay for brand-name as well as generic drugs
- May have rules for managing access

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Your Medicare Rights and Protections

- Medicare drug plans work to provide people with Medicare high-quality, cost-effective drug coverage. Medicare drug plans must ensure that their enrollees can get medicallynecessary drugs to treat their conditions.
- Each plan has a list of covered drugs called a formulary.
- A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.
- Plans must pay for both brand-name and generic drugs.
- Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze are also covered.
- Some of the methods that plans use to manage access to certain drugs include:
  - Formularies
  - Prior authorization
  - Step therapy
  - Quantity limits

## **Access to Covered Drugs**

- Plans must cover all medications in six categories
  - Was "all or substantially all" medications
  - Affordable Care Act changed this to "all"
- Categories
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments for epilepsy/other conditions
  - Immunosuppressants

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Your Medicare Rights and Protections

- CMS requires Medicare drug plans to cover all medications in six categories. This was "all or substantially all" medications in six categories, but Section 3307 of the Affordable Care Act has change this to "all." The six categories include
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments for epilepsy and other conditions; and
  - Immunosuppressants

## **Transition Supply**

- Plans must fill prescriptions not on plan's list
  - For new enrollees
  - For residents of long-term care facilities
- Immediate supply provided to new enrollee
  - Fill one-time, 30-day supply of current prescription
- While using transition supply
  - Work with doctor to switch to drug on plan's list
  - If medically necessary, request an exception
  - Don't wait until supply runs out to take action

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Your Medicare Rights and Protections

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- Some new members may already be taking a drug that's not on their plan's drug list or that is a step therapy drug\*. Medicare requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs, even if the prescription is for a drug that's not on the plan's drug list, is a step-therapy drug\*, or requires prior authorization. This gives you and your doctor time to find another drug on the plan's drug list that would work as well. However, if you have already tried similar drugs and they didn't work, or if the doctor believes that because of your medical condition you must take a certain drug, the doctor can contact the plan to request an exception to the formulary rules. If the doctor's request is approved, the plan will cover the drug. If the exception is not granted, you can file an appeal.
- It is important to understand how to work with your plan's formulary and to plan ahead. If you receive a transition supply, you shouldn't wait until that supply is gone to take action. You should talk to your doctor about:
- Prior authorization (if necessary)
- Safe and effective alternative drugs that may also save you money
- Requesting an exception, if necessary for your condition
- You should contact your drug plan with any questions about what is covered by the plan.

**Note**: In most cases with step therapy drugs, the plan member must first try certain less-expensive drugs that have been proven effective for most people with that condition.

## **Request a Coverage Determination**

- You or prescriber may request determination
  - A drug you believe should be covered isn't covered
  - A drug is covered at a higher cost
  - You have to meet a plan coverage rule
  - It won't cover a drug on the formulary
- Request before you pay or decide to pay
- File a standard or expedited request

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Your Medicare Rights and Protections

- You or your prescriber may request a coverage determination if your pharmacist or plan tells you one of the following:
  - A drug you believe should be covered isn't covered
  - A drug is covered at a higher cost than you think you should have to pay
  - You have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested
  - It won't cover a drug on the formulary because the plan believes you don't need the drug
- You can either request a coverage determination before you pay for or get your prescriptions, or you may decide to pay for the prescription, save your receipt, and request that the plan pay you back when requesting a coverage determination.
- You, your doctor, or other prescriber may request a coverage determination by following the instructions that your plan sends you. You can file a standard request or an expedited (fast) request
- If you disagree with your plan's decision, you may appeal.

# Request an "Exception"

#### Request an exception

- You think plan should cover a drug not on its formulary
- Your plan requires you to get permission (prior authorization)
- You think your plan should charge you a lower amount
- Your plan asks you to try another drug
- Your plan has a limit on the number of pills or dosage
- Doctor /prescriber believes you can't meet one of coverage limits.

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Your Medicare Rights and Protections

- You, your doctor, or other prescriber may request an exception if:
  - You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you.
  - Your plan requires you to get permission (prior authorization) before it covers a drug prescribed for you and you disagree.
  - You think your plan should charge a lower amount for a drug you are taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.
  - Your plan asks you to try another drug before it covers a drug prescribed for you and you disagree.
  - Your plan has a limit on the number of pills or dosage for a drug prescribed for you and you disagree.
  - Your doctor or other prescriber believes you can't meet one of your plan's coverage limits, such as prior authorization, quantity limit, or dose limits.

# **Request an Exception**

- May need to call or send a supporting statement
- File a standard or expedited request

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Your Medicare Rights and Protections

- To request a coverage determination called an "exception," your doctor or other prescriber may need to call or send your plan a supporting statement explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required and if it must be made in writing. If a supporting statement is required, the plan's decision-making time period begins once your plan gets the supporting statement.
- You may file a standard or expedited (fast) request.
- If you disagree with the decision, you have the right to appeal

## **Tier Exception**

- Access to non-preferred drug
  - At lower cost of drugs in the preferred tier
  - If plan's preferred drug
    - · Would not be as effective
    - · Would have adverse effects

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Your Medicare Rights and Protections

- If a plan uses a tiered cost-sharing structure to manage its Medicare drug benefit, it must provide exceptions procedures that permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing level for drugs in the preferred tier.
- A plan must grant a tier exception when it determines that the preferred drug for treatment of your condition would not be as effective for you as the requested drug and/or it would have adverse effects.
- When a tier exception is approved, the plan must provide coverage at the cost-sharing level that applies for preferred drugs, but not at the generic cost-sharing level. Also, if a plan maintains a formulary tier in which it places very high cost and unique items, it may design its exception process so that drugs placed in that tier are not eligible for a tier exception.

# **Formulary Exceptions**

- Access to Medicare-covered drugs
  - Not included on the plan's formulary or
  - Plan has special coverage rules
- Special rules include
  - Prior authorization
  - Quantity limits
  - Step therapy
- Plan can determine the level of cost sharing

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Your Medicare Rights and Protections

- Formulary exceptions ensure enrollees have access to Medicare-covered drugs that are not included on the plan's formulary or for which the plan has special coverage rules. These special rules include: prior authorization, quantity limits, and step therapy.
- When a formulary exception is approved, the plan has the flexibility to determine the level of cost sharing that will apply for the non-formulary drug(s). For example, a plan sponsor may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.

# **Formulary Exceptions**

- Plan must grant a formulary exception
  - Formulary alternatives not as effective
  - Would have adverse effects
- Plan must grant an exception to a coverage rule
  - Coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition or
  - Has caused, or is likely to cause harm, to enrollee

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A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or would have adverse effects. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused, or is likely to cause harm, to the enrollee.

## **Approved Exceptions**

- Exception valid for remainder of year
  - Member must remain enrolled and
  - Prescriber continues to prescribe drug and
  - Drug stays safe to treat person's condition
- Plan may extend coverage into new plan year
- Plan must notify enrollee in writing
  - Coverage not extended
  - Date coverage will end
  - Right to request new exception

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Your Medicare Rights and Protections

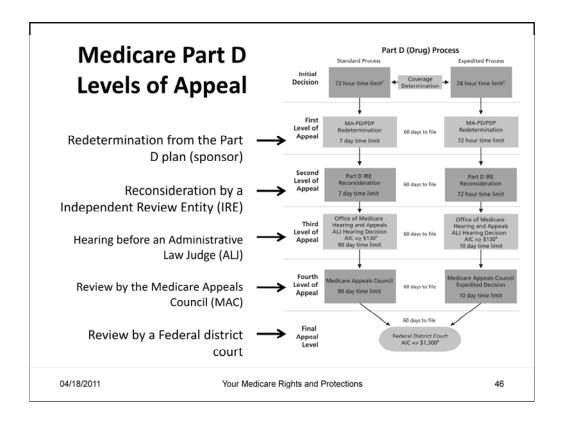
- If an exception request is approved, the exception is valid for refills for the remainder of the plan year so long as:
  - The member remains enrolled in the plan,
  - The physician continues to prescribe the drug, and
  - The drug remains safe for treating the person's condition.
- A plan may choose to extend coverage into a new plan year. If it does not, it must provide written notice to the member either at the time the exception is approved, or at least 60 days before the plan year ends. The written notice must tell the member about the date coverage will end, the right to request a new exception, and the process for making a new exception request. If coverage isn't extended, the member should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during the Annual Coordinated Enrollment Period.

# **Requesting Appeals**

- Request appeal if coverage request denied
- Denial notice will explain how to request appeal
- Five levels in the appeals process

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- When requesting appeals
  - Request an appeal if your coverage determination request is denied
  - The denial notice will explain how to request an appeal and the process for requesting the appeal
  - There are five levels of appeal in the appeals process



- If you receive an unfavorable initial decision, you have the right to appeal the decision. There are 5 levels of appeal
  - 1. Redetermination from the Part D plan (sponsor)
  - 2. Reconsideration by an Independent Review Entity (IRE)
  - 3. Hearing before an Administrative Law Judge (ALJ)
  - 4. Review by the Medicare Appeals Council
  - 5. Review by a Federal district court

Note: This chart is available in the corresponding workbook (see Appendix D).

# **Required Notices**

- At pharmacy counter
  - Whenever prescription is not filled as written
- After every coverage determination
- After every appeal decision
- Adverse decisions
  - Must include information on the next appeal level
  - Must include specific filing instructions

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Your Medicare Rights and Protections

- Plan sponsors must ensure that their network pharmacies provide the Pharmacy Notice whenever a prescription cannot be filled as written.
- Plans sponsors are required to provide written notices after every coverage determination or appeal decision.
- In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse, the notice will explain the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.

#### Health Plans' Disclosure of PHI

- Personal Health Information (PHI)
  - Plan may disclose relevant PHI to people you identify
  - Family member or other relatives
  - Close personal friend
  - Others (see examples on next slide)
- May disclose PHI only under certain conditions

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Your Medicare Rights and Protections

- A health-care provider or plan, such as a Medicare drug plan, may disclose relevant protected health information (PHI) to someone who assists you, specifically regarding the drug benefit. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.
- Your plan may disclose relevant PHI to those identified by you as being involved in your care or payment, including the following.
  - Family members or other relatives
  - Close personal friends
  - Others (see examples on next slide)
- Your plan may disclose relevant PHI to those identified by you only under the following conditions.
  - When you are present and agree or the plan reasonably infers from the circumstances that you do not object
  - When you are not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest

# When Plans May Disclose PHI

- To a daughter or son
  - To resolve claim or payment issue for parent in hospital
- To human resources representative
  - If you are on the call or give permission by phone
- To Congressional office
  - That faxed your request for Congressional assistance
- To CMS
  - Information satisfies plan you requested CMS assistance

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- Examples of when a plan may disclose PHI
  - To the daughter of a person with Medicare who is resolving a claim or payment issue for her hospitalized mother
  - To a human resources representative if the person with Medicare is on the line or gives permission by phone
  - To a Congressional office or staff person that has faxed the person's request for Congressional assistance
  - To CMS staff if the available information satisfies the plan that the individual requested CMS assistance

**Note**: PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services.

## **Exercise**

- A. Which statement below is true?
  - 1. Exceptions are always extended into the new plan year.
  - 2. Plans are not required to fill prescriptions not on plan's list for residents of long-term care facilities.
  - 3. Plans must cover all drugs in six categories.

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Your Medicare Rights and Protections

# **Exercise**

- B. Medicare Prescription Drug Plans always provide generic drugs at no cost.
  - 1. True
  - 2. False

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Your Medicare Rights and Protections

# 5. Your Rights in Other Settings

- A brief explanation of your rights
  - Hospital
  - Skilled Nursing Facility (SNF)
  - Home Health Care
  - Hospice
  - Comprehensive Outpatient Rehabilitation Facility (CORF)

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Your Medicare Rights and Protections

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■ If you are admitted to a hospital or skilled nursing facility, or you are receiving care from a non-institutional provider, such as home health, hospice, or a comprehensive outpatient rehabilitation facility (CORF,) you are guaranteed certain rights and protections. Many of these rights and protections are the same whether you are in Original Medicare, Medicare Advantage Plan (like an HMO or PPO), or other Medicare health plan.

# **Right to Hospital Care**

- Right to medically-necessary, Medicare-covered hospital care
  - To diagnose an illness
  - To treat an illness or injury
  - To get follow-up care
- You will receive a notice when admitted to hospital
  - "Important Message From Medicare About Your Rights"

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Your Medicare Rights and Protections

- All people with Medicare, including those in Medicare Advantage or other Medicare health plans, have the right to get all of the Medicare-covered hospital care they need to diagnose and treat their illness or injury, including any follow-up care they need after leaving the hospital.
- When admitted to the hospital as an inpatient, you will receive a notice called an *Important Message From Medicare About Your Rights* and the hospital must provide you with a copy of the notice so that you know your rights as a hospital inpatient.

## "Important Message from Medicare"

- Signed by you and copy provided explaining
- Notice explains your rights
  - Get all medically-necessary hospital services
  - Be involved in any decisions
  - Get services you need after you leave the hospital
  - Appeal discharge decision and steps for appealing decision
  - Circumstances in which your hospital services may be paid for during the appeal

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Your Medicare Rights and Protections

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- During your hospital stay, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM") that you (or your representative) must sign. You should get this notice if you're in Original Medicare or a Medicare Advantage plan. If you don't get this notice, ask for it. This notice explains the following:
  - Your right to get all medically-necessary hospital services related to the condition for which your were admitted
  - Your right to be involved in any decisions that the hospital ,your doctor, or anyone else makes about your hospital services and to know who will pay for them
  - Your right to get services you need after you leave the hospital
  - Your right to appeal a discharge decision and the steps for appealing the decision
  - The circumstances in which your hospital services may be paid for during the appeal (except for any applicable coinsurance or deductibles)
  - What you might pay for continuing to stay in the hospital after your discharge date
  - Information on your right to get a detailed notice about why your covered services are ending
  - Your right to report any concerns you have about the quality of care you receive
- If the hospital gives you the "Important Message from Medicare" more than 2 days before your discharge day, it must either give you a copy of your original, signed "Important Message from Medicare" or provide you with a new one (that you must sign again) before you're discharged.

**Note:** A copy of the Important Message from Medicare is provided in the back of the corresponding workbook (see Appendix E). It is also available on the web at cms.gov/BNI/12 HospitalDischargeAppealNotices.asp.

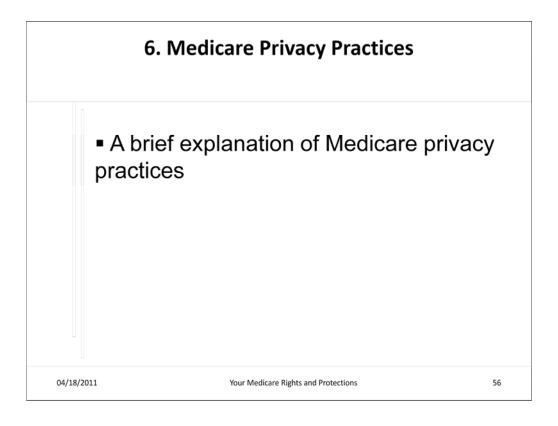
## **Plan Fast Appeals Process**

- "Notice of Medicare Non-Coverage"
  - Delivered at least 2 days before care will end
- Contact QIO if services are ending too soon
  - See your Notice for how to contact your
     QIO
- QIO must notify you of its decision
  - COB the day after receiving information

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Your Medicare Rights and Protections

- With the Medicare Health Plan Fast Appeals Process:
  - You have the right to ask the Quality Improvement Organization (QIO) to require your plan
    to provide or pay for a Medicare-covered service you think should be continued in a skilled
    nursing facility, from a home health agency, or in a comprehensive outpatient rehabilitation
    facility.
  - Your provider must deliver a Notice of Medicare Non-Coverage at least 2 days before Medicare-covered SNF, CORF, or HHA care will end.
- If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal.
  - See your Notice for how to contact your QIO and for other important information.
- The QIO must notify you of its decision by close of business of the day after it receives all necessary information.
  - The plan must give you a Detailed Explanation of Non-Coverage. This notice will explain why
    the coverage is being discontinued.
  - You have the right to ask for a reconsideration by the QIC (Qualified Independent Contractor) if you are dissatisfied with the results of the fast appeal.



• Medicare has special rules that protect your privacy. You are probably aware of some of these rules when you visit the doctor or pick up a prescription.



■ Medicare is required to protect your personal medical information. The *Notice of Privacy* 

# **Required Disclosures**

- Medicare must disclose your medical information
  - To you
  - To someone with the legal right to act for you
  - To the Secretary of Health & Human Services
  - When required by law

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Your Medicare Rights and Protections

- Medicare **must** disclose your personal medical information:
  - To you or someone who has the legal right to act for you (your personal representative)
  - To the Secretary of Health and Human Services, if necessary, to make sure your privacy is protected
  - Where required by law

#### **Permitted Disclosures**

- Medicare may disclose medical information
  - To pay for your health care
  - To operate the program
  - Examples
    - To Medicare contractors to process your claims
    - To ensure you get quality health care
    - To provide you with customer service
    - To resolve your complaints
    - To contact you about research studies

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Your Medicare Rights and Protections

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Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program.

- Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer services to you, or to resolve any complaints you have, or to contact you about research studies.

#### **Other Permitted Disclosures**

- Medicare may disclose your medical information
  - To state and Federal agencies
  - For public health activities
  - For government oversight
  - For judicial proceedings
  - For law enforcement purposes
  - To avoid a serious threat to health and safety
  - To contact you regarding a Medicare benefit
  - To create a non-traceable collection of information

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Your Medicare Rights and Protections

- Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances.
  - To state and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/state Medicaid programs)
  - For public health activities (such as reporting disease outbreaks)
  - For government health care oversight activities (such as fraud and abuse investigations)
  - For judicial and administrative proceedings (such as in response to a court order)
  - For law enforcement purposes (such as providing limited information to locate a missing person)
  - To avoid a serious threat to health or safety
  - To contact you regarding a new or changed Medicare benefit
  - To create a collection of information that can no longer be traced back to you

# Additional Privacy Rights and Protections

- Medicare needs written permission (authorization)
- You may revoke your permission at any time

04/18/2011 Your Medicare Rights and Protections

 By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice.
 You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

### **Privacy Rights**

- See and copy your personal medical information
- Correct medical information you believe is wrong or incomplete
- Know who your medical information was sent to
- Communicate in a different manner
- Ask Medicare to limit use of your medical information
  - To pay your claims and run the program
- Get a written privacy notice

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Your Medicare Rights and Protections

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- You have the following privacy rights. You may
  - See and copy your medical information held by Medicare
  - Correct any incorrect or incomplete medical information
  - Find out who received your medical information for purposes other than paying your claims, running the Medicare program, or for law enforcement
  - Ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. box instead of your home address)
  - Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request
  - Ask for a separate paper copy of these privacy practices



If you want information about the privacy rules, call 1- 800- MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

# If Privacy Rights Are Violated

#### You may file a complaint

- Call 1-800-MEDICARE (1-800-633-4227)
   TTY users should call 1-877-486-2048 or
- Contact HHS Office for Civil Rights
  - Visit hhs.gov/ocr/office/index.html or
  - Call 1-866-627-7748. TTY users should call 1-800-537-7697.
- Will not affect your Medicare benefits

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Your Medicare Rights and Protections

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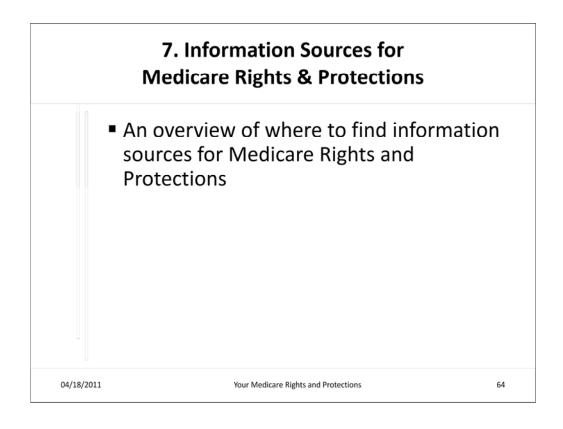
- If you believe Original Medicare has violated your privacy rights, you may file a complaint.
- You can file a complaint by:



Calling 1-800-MEDICARE (1-800-633-4227) and ask to speak with a customer service representative. TTY users should call 1-877-486-2048 or

Contacting the HHS Office for Civil Rights at hhs.gov/ocr/hipaa or by calling 1-866-627-7748. TTY users should call 1-800-537-7697.

■ Your complaint will not affect your benefits under Medicare.



• Other relevant information and resources are available to help you.

#### **Advanced Directive**

- Protect yourself
- Let people know your wishes now
  - Should a time come when you can't speak for yourself
- Complete a "health care advance directive"
  - Identifies who you want to speak for you
  - What kind of health care you want
  - What kind of health care you don't want

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Your Medicare Rights and Protections

- As people live longer, there is a greater chance that they may not be able to make their own health care decisions at some point in time. Alzheimer's and other diseases affect your ability to make health care decisions.
- Making future health care decisions is another health care protection available to anyone, not just people with Medicare. Check for your state's requirements.
- Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include; a health care proxy (durable power of attorney), a living will, and after-death wishes.
- Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure your wishes are followed. It's better to think about these important decisions before you are ill or a crisis strikes.
- A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.
- A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened, e.g.; dialysis for kidney failure, a breathing machine if you can't breathe on your own, CPR (cardiopulmonary resuscitation) if your heart and breathing stop, or tube feeding if you can no longer eat.

#### **Medicare Ombudsman**

- Works to ensure people with Medicare
  - Get information and help they need
  - Understand their Medicare options
  - Apply their rights and protections
- May identify and track issues
  - Payment policies
  - Coverage policies

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Your Medicare Rights and Protections

- Another protection for people with Medicare is the Medicare Beneficiary Ombudsman's office. The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections.
- The Ombudsman may identify issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.

#### **Medicare Ombudsman**

- Ensures prompt organization response
  - Need help filing an appeal
  - Have a problem joining/leaving MA Plan
  - Have questions about Medicare premiums
  - Need help understanding rights/protections

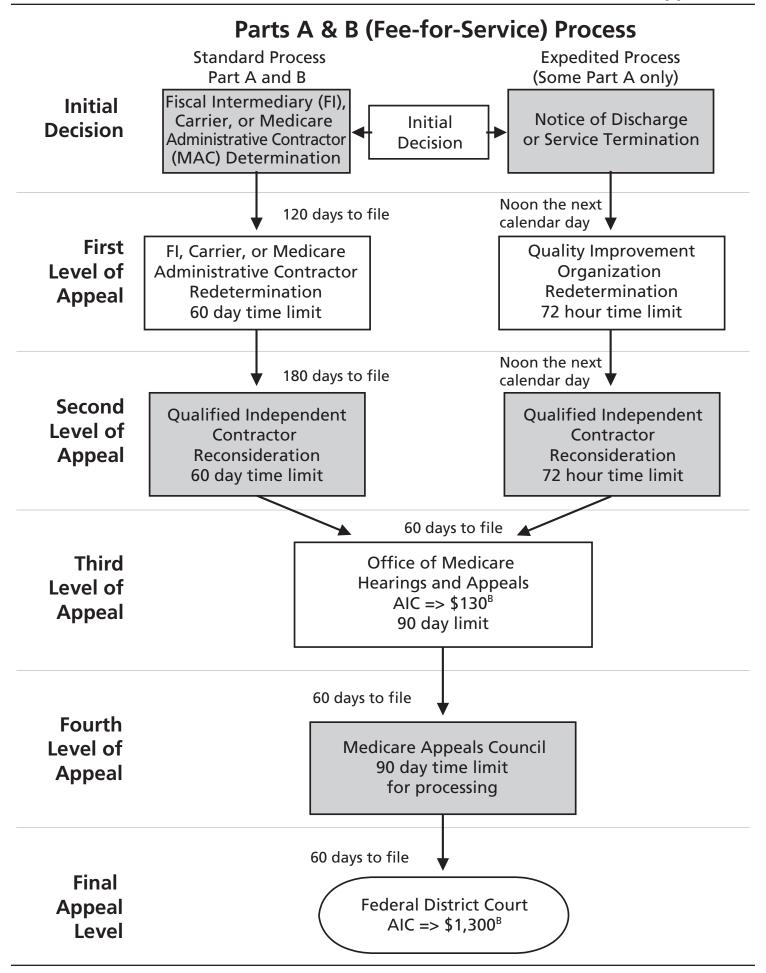
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Your Medicare Rights and Protections

- The Medicare Ombudsman works to make sure the organizations that should help you with your complaints, appeals, grievances, or questions about Medicare work the way they should and respond to you promptly.
- For example, the Medicare Beneficiary Ombudsman can help in the following situations.
  - You need help to file an appeal
  - You have a problem joining or leaving a Medicare Advantage Plan (like an HMO or PPO)
     or other Medicare plan, or a Medicare Prescription Drug Plan
  - You have questions about Medicare premiums
  - You need help understanding your Medicare rights and protections

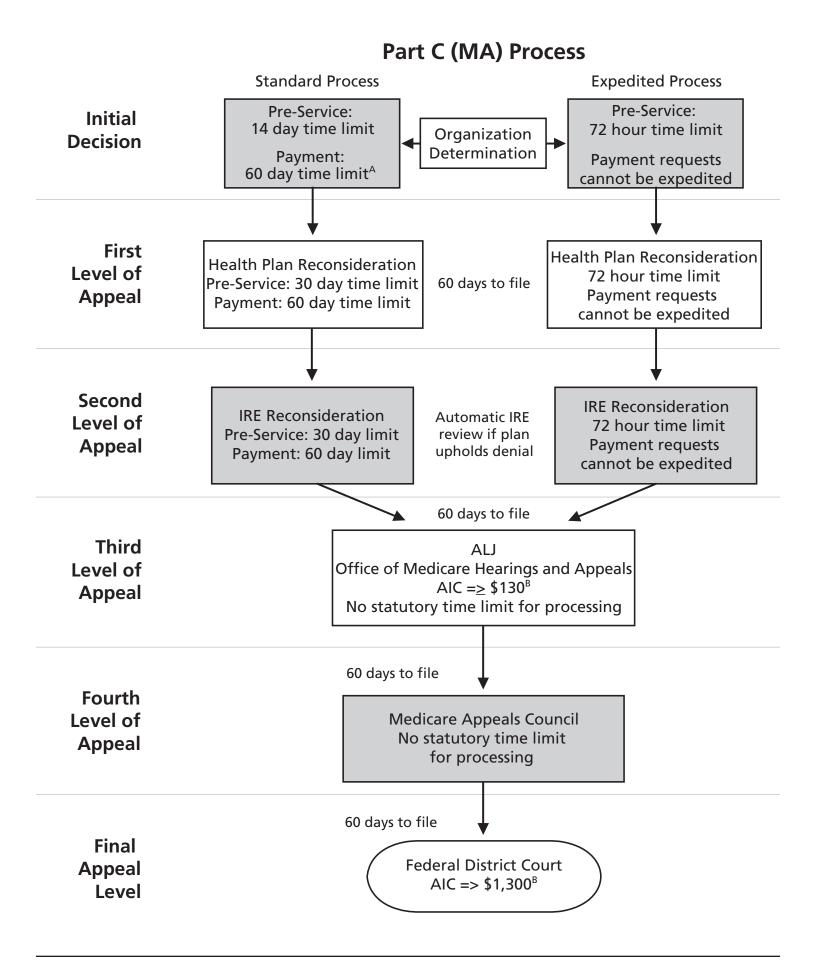
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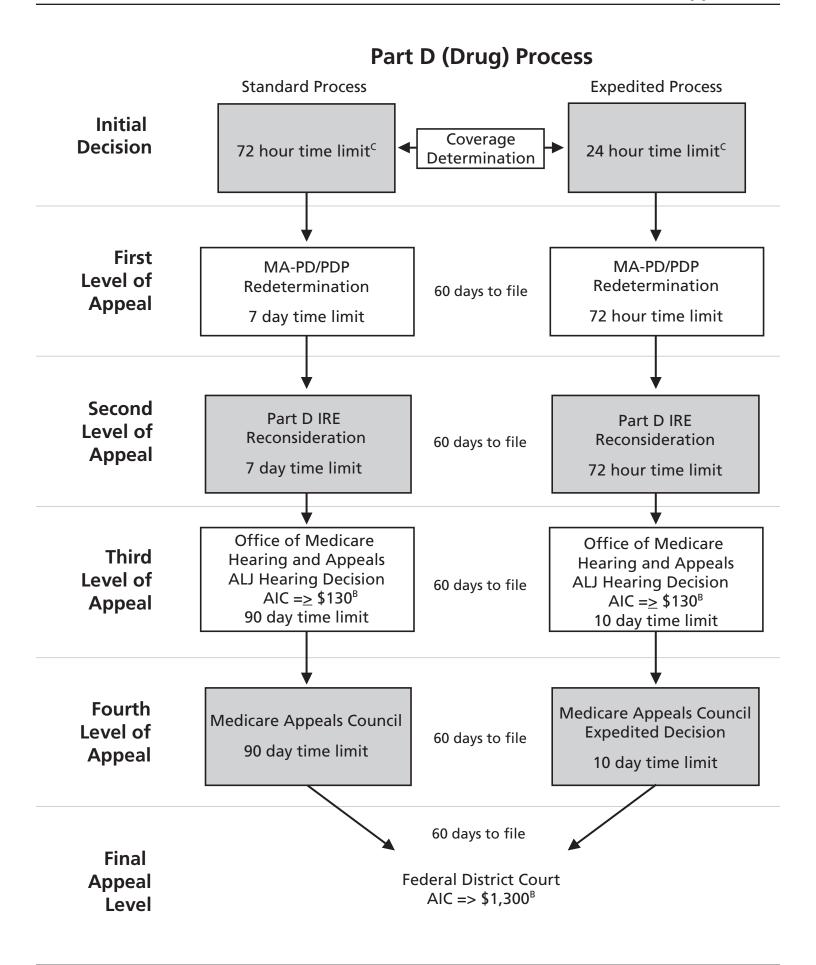
Resources	es	Medicare Products
Centers for Medicare & Medicaid Services (CMS)	State Health Insurance Assistance Programs (SHIPs)*	<i>Medicare &amp; You Handbook</i> CMS Product No. 10050)
1-800-MEDICAKE (1-800-633-4227) (TTY 1-877-486-2048)	State Quality Improvement Organization (QIO)	<b>Your Medicare Rights &amp; Protections</b> CMS Product No. 10112
Medicare.gov	Independent Review Entity (MA & Part D claims only)	To access these products: View and order single copies at Medicare.gov
cms.gov/center/ombudsman.asp	*For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users	Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.
Dept. of Health & Human Services Office of Civil Rights  hhs.gov/ocr/office/index.html  1-866-627-7748  1-800-537-7697 for TTY users		



(A) Notifier(s): (B) Patient Name:	(C) Identification Number:	
ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)  NOTE: If Medicare doesn't pay for (D) below, you may have to pay.		
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the <b>(D)</b>		
(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
WHAT YOU NEED TO DO NOW:		
<ul> <li>Read this notice, so you can make an informed decision about your care.</li> <li>Ask us any questions that you may have after you finish reading.</li> <li>Choose an option below about whether to receive the (D) listed above.</li> <li>Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.</li> </ul>		
(G) OPTIONS: Check only one box. We cannot choose a box for you.		
<b>OPTION 1.</b> I want the <b>(D)</b> listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.		
<b>OPTION 2.</b> I want the <b>(D)</b> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.		
OPTION 3. I don't want the (D)listed above. I understand with this choice		
I am <b>not</b> responsible for payment, and I cannot appeal to see if Medicare would pay.  (H) Additional Information:		
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call <b>1-800-MEDICARE</b> (1-800-633-4227/ <b>TTY</b> : 1-877-486-2048).		
Signing below means that you have received and understand this notice. You also receive a copy.		
(I) Signature:	(J) Date:	
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.		

Form CMS-R-131 (03/08)





## **NOTES:**

## **NOTES:**



E-mail: NMTP@cms.hhs.gov Website: cms.gov/NationalMedicareTrainingProgram

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Baltimore, MD 21244